

Managed MaineCare Initiative Update for Potential Vendors

December 10, 2010

All documents and materials concerning the Managed Care project reflect MaineCare's current thinking and are subject to change. No materials on the managed care web page, distributed and discussed at meetings or sent in emails or mailings are binding in any way concerning the future procurement process.

Agenda



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- | | |
|---|---------------|
| • Introduction and Background of Managed Care Initiative | 9:00 - 9:30 |
| <i>Tony Marple, Director—Office of MaineCare Services</i> | |
| • Purchasing Office Presentation | 9:30 – 9:45 |
| <i>Chad Lewis, RFP Manager—Division of Purchased Services</i> | |
| • Overview of the Proposed Program Model Design | 9:45 – 10:30 |
| <i>Jim Hardy, Deloitte Consulting</i> | |
| • Participant Question and Answer/Feedback Session #1 | 10:30 – 11:00 |
| <i>Nadine Edris, Muskie School of Public Service</i> | |
| • Break | 11:00 – 11:10 |
| • Update from Bureau of Insurance | 11:10 – 11:25 |
| <i>Kendra Godbout & Joanne Rawlings-Sekunda, BOI</i> | |
| • Overview of Proposed Populations and Services | 11:25 – 11:40 |
| <i>Julie Fralich, Muskie School of Public Service</i> | |
| • Participant Question and Answer/Feedback Session #2 | 11:40 – 12:25 |
| <i>Nadine Edris, Muskie School of Public Service</i> | |
| • Next Steps | 12:25 – 12:30 |
| <i>Stefanie Nadeau, Office of MaineCare Services</i> | |

Session Objectives

- Provide background and goals of the Managed MaineCare initiative
- Offer preview of Maine's initial program design ideas for managed care
- Articulate the initiative's proposed timeline and process
- Receive feedback from vendors
- Answer questions

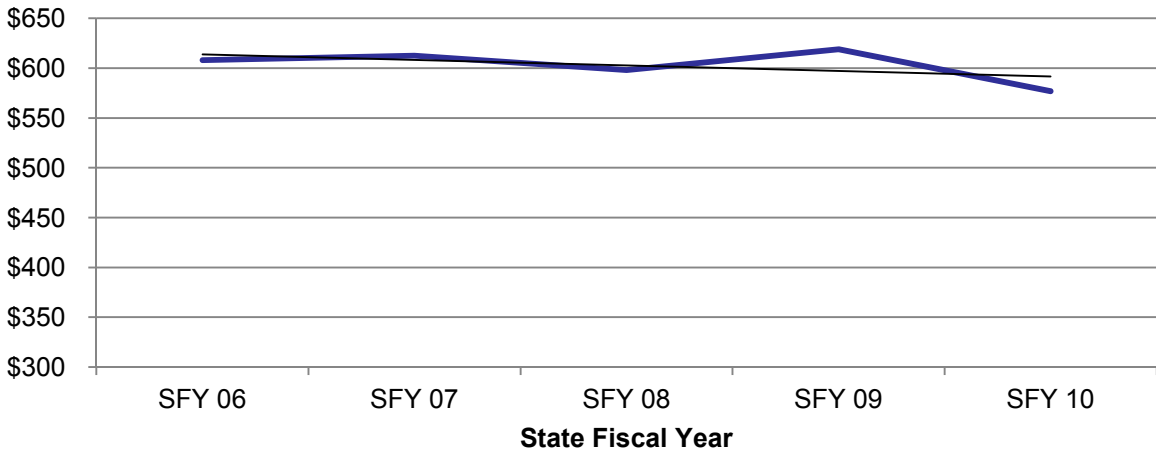


Spending and Enrollment Information

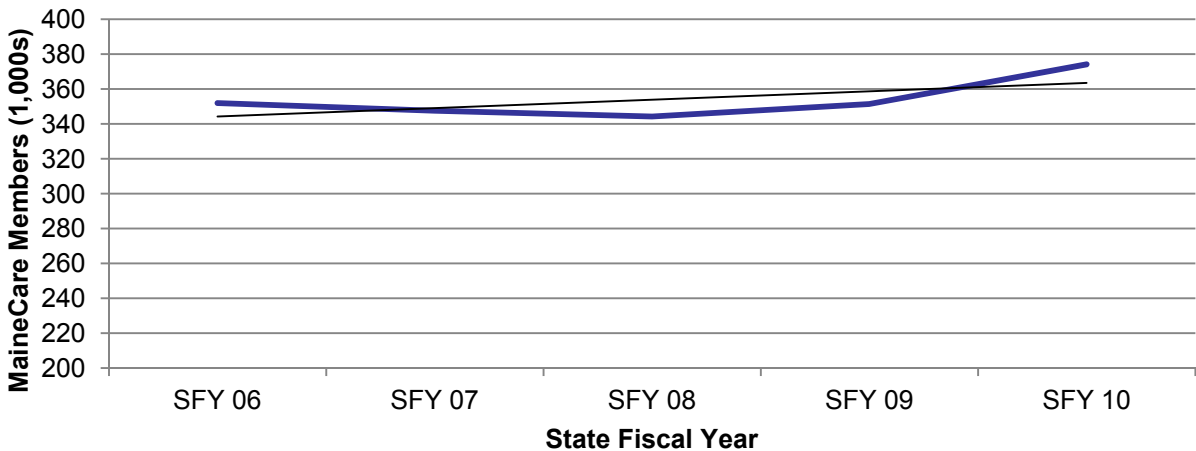


Four year trends show MaineCare enrollment increasing while costs are decreasing.

MaineCare Total Actual PMPM

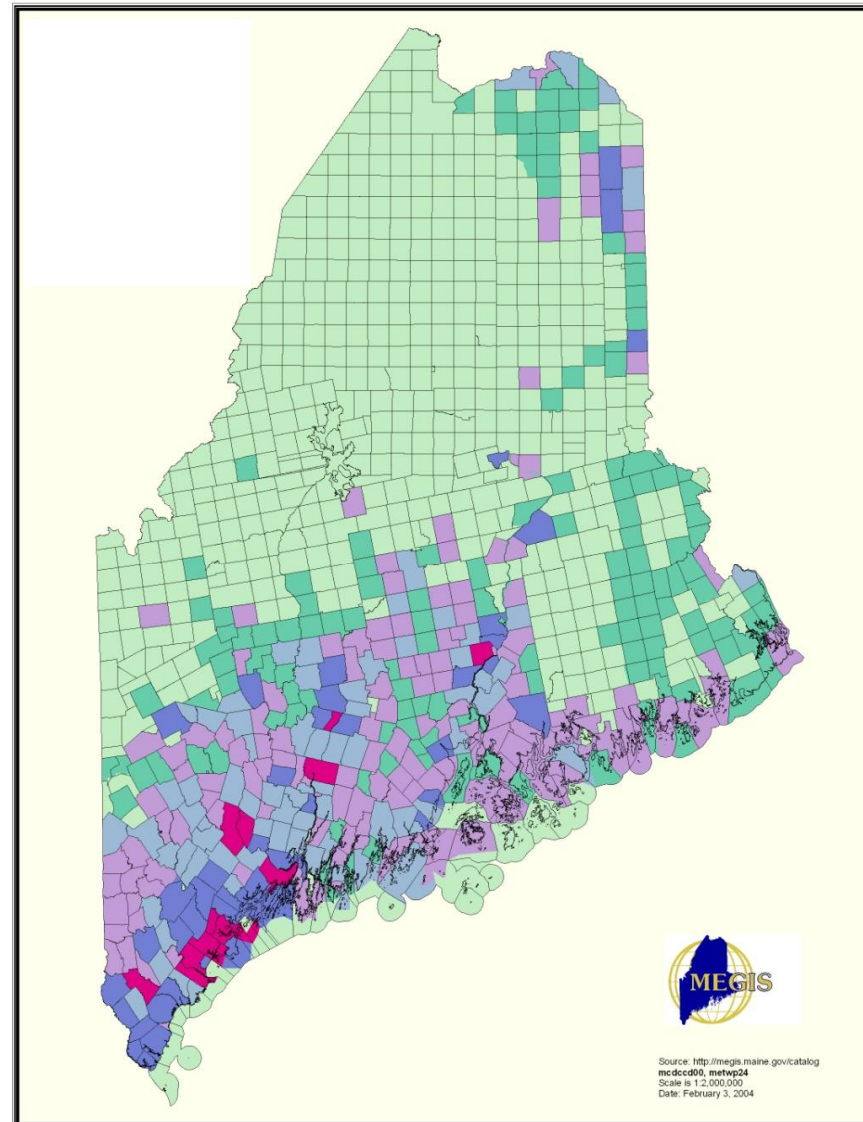
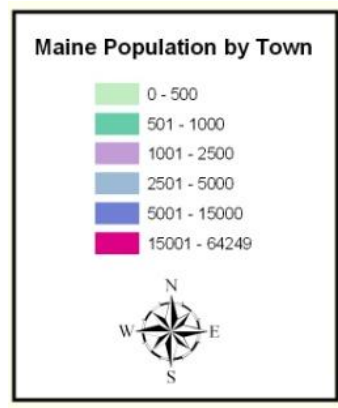


MaineCare Enrollment



Maine Population Characteristics

Maine's population is heavily concentrated, despite its large geographic footprint.



Source: Maine Office of GIS
http://megis.maine.gov/maps/newimages/mainepop_300.jpg

Initiative Background

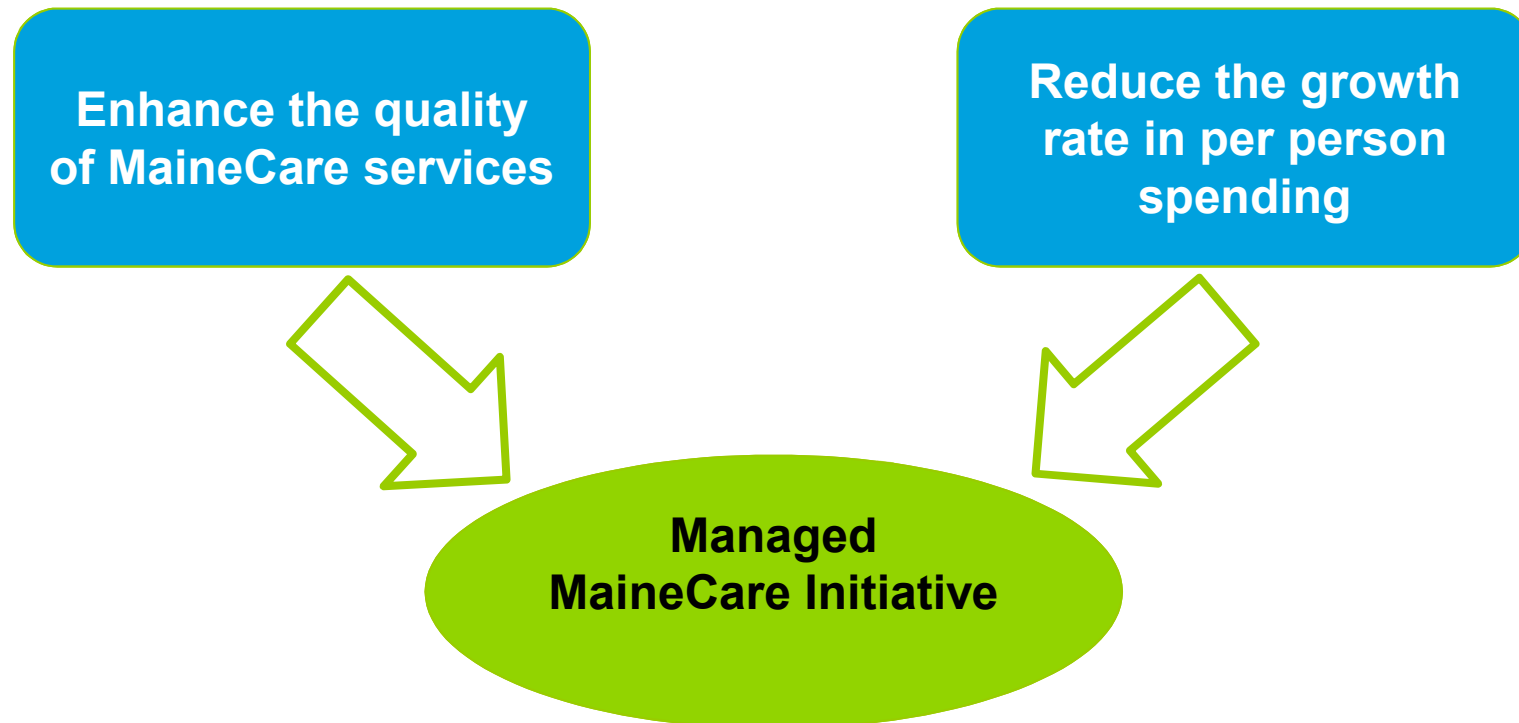


- The State of Maine Legislature mandated a feasibility study of risk contracting in the MaineCare program, which was completed in March 2010
- Based upon the findings, the Legislature appropriated development funds, specified stakeholder groups and regular reporting requirements
- MMI anticipates a three-year phase-in of populations and services beginning January 1, 2012
- To accomplish this goal, the MMI team is working to develop an RFP by May 1, 2011

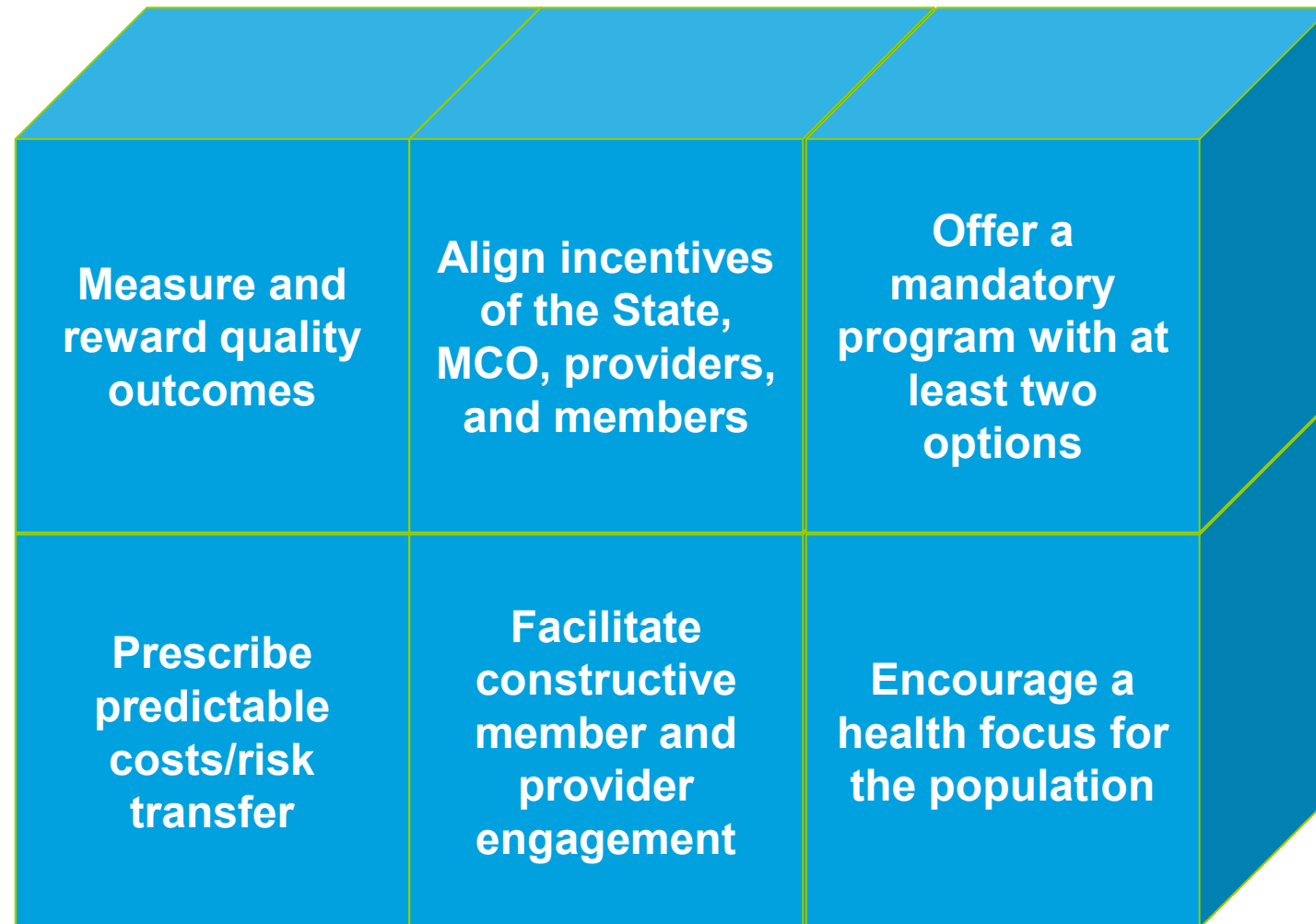
Initiative High-Level Timeline



Goals of Initiative



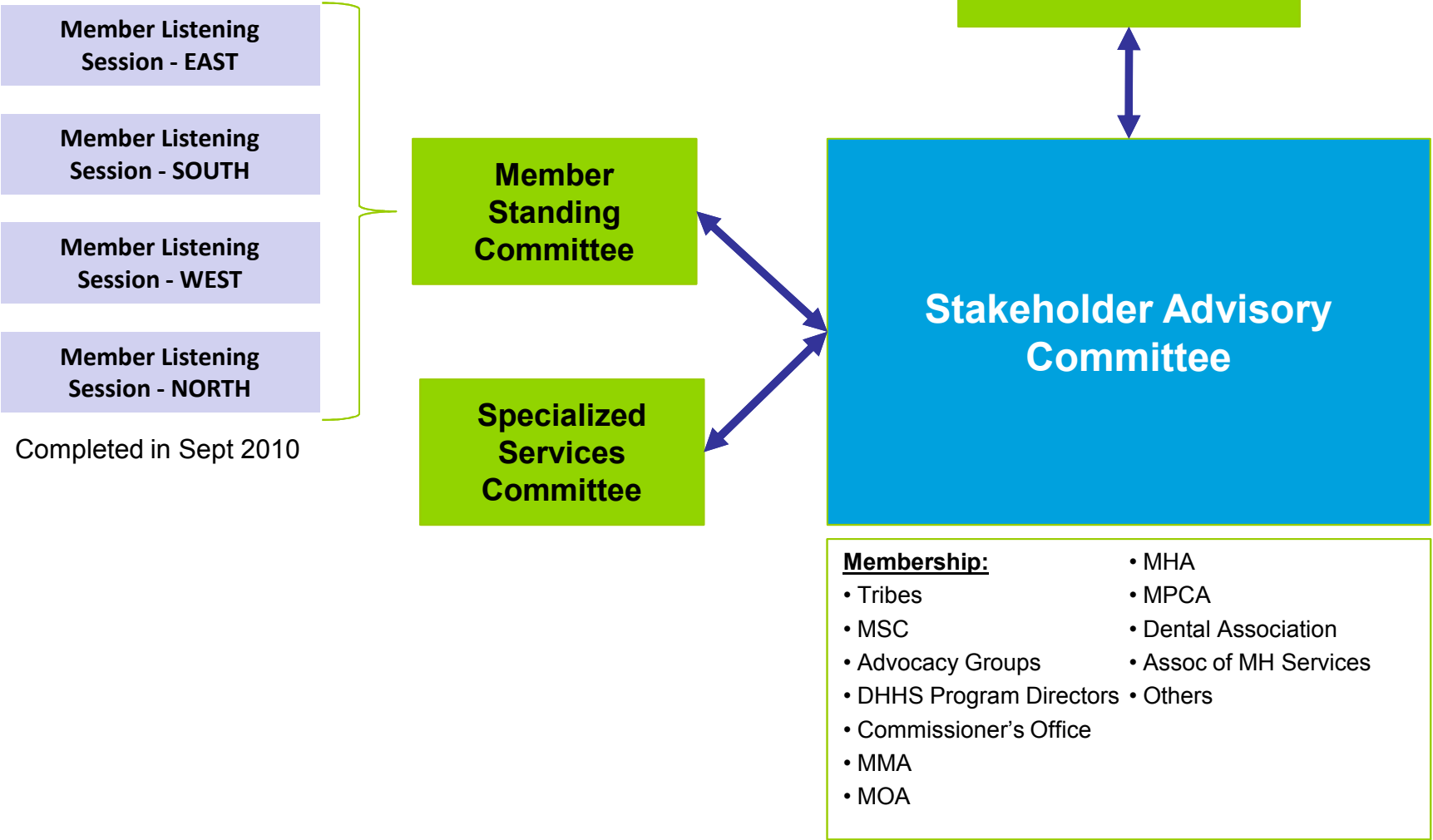
Key Initiative Objectives



Stakeholder Input

Stakeholder input, including member input, continues to shape the program design

Regional Focus Groups



MaineCare Listening Sessions: Report Summary

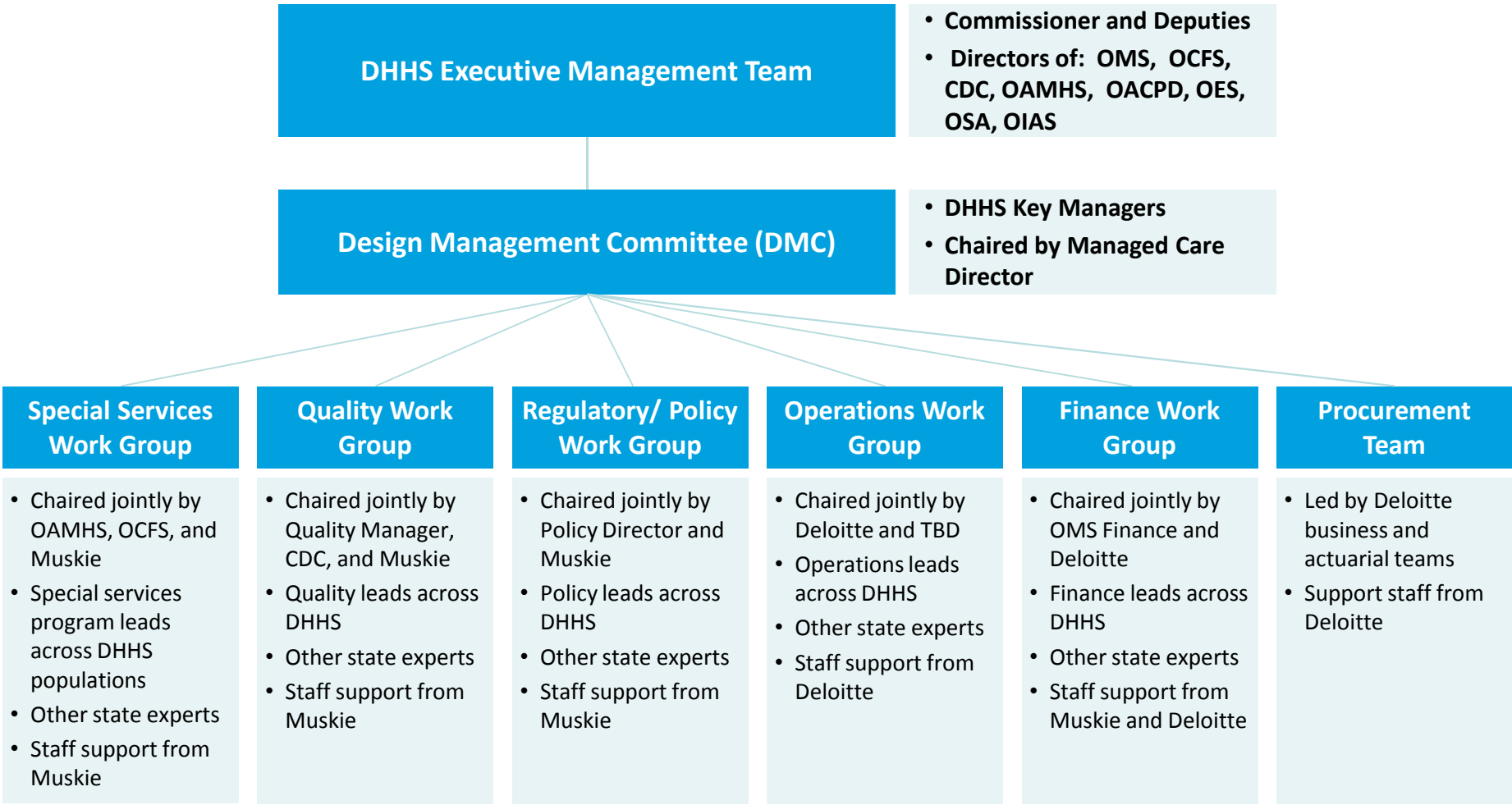


- The Muskie School conducted four Listening Sessions in September 2010 in Portland, Lewiston, Bangor and Presque Isle, with 50 total MaineCare members.
- The goal was to gather in-depth information about their experiences with the MaineCare program.

Major, statewide themes identified:

- Many members are appreciative of the services they receive through MaineCare
- Better patient/member supports would improve care
- Members report lack of access to mental health providers
- Prior Authorization (PA) for medications and changes in the Preferred Drug List (PDL) cause problems for members
- Transportation access and timeliness need improvement
- Sometimes access to PCPs and specialists is difficult
- Members strongly support dental coverage for adult MaineCare members
- Paperwork sent from the Department is often redundant and communication could be improved
- Prevention should be a priority in MaineCare

Initiative Project Structure



Overview from Purchasing Division

Purchasing – General Information



RFP advertised in official state paper:
Kennebec Journal

Purchases Website:
<http://www.maine.gov/purchases/rfp/index.html>

Register, and view/download the RFP:
<http://www.maine.gov/dhhs/rfp/>

Contract Information:
<http://www.maine.gov/dhhs/purchased-services/contract-2011/index.html>

RFP Announcement Template



State of Maine Department of Health & Human Services

REQUEST FOR PROPOSALS RFP# (Enter Purchases assigned RFP#) (RFP Title)

The State of Maine, Department of Health and Human Services is seeking proposals to

(Enter info)

RFP Coordinator: Request RFP Instruction Package, Questions, Letter of Intent:

[INSERT NAME, ADDRESS, PHONE, E-MAIL]

and 1-800-606-0215 for the Deaf or Hard of Hearing. Please give your full name, address and phone number; specify RFP by number and title. **OR:** You may register and download the RFP directly from the State's internet site: <http://www.maine.gov/dhhs/rfp/>

BIDDERS CONFERENCE: (DATE/TIME/PLACE)

QUESTIONS must be in writing, due no later than 5:00 pm local time, **DATE.**

LETTER OF INTENT DUE: no later than 5:00 pm local time, **DATE.**

COMPLETED PROPOSALS must be received and will be opened **NO LATER THAN 2:00 pm local time, Day, Month DD, 20YY** at the following address: Division of Purchases; Burton Cross State Office Building (Fourth Floor), 111 Sewall ST; 9 State House Station, Augusta ME 04333-0009. Proposal package(s) must be labeled with the RFP number and title. **We do NOT accept faxed proposals.**

RFP Cover Page Template



MAINE DEPARTMENT OF HEALTH AND HUMAN SERVICES (Division/Office)

RFP# (RFP#-assigned by Purchases)

(RFP TITLE)

REQUEST FOR PROPOSAL INSTRUCTION PACKAGE

Approved by State Purchases Review Committee – (date)

Bidders Conference: (date, time & location)

Deadline for Written Questions: (date), 4:00 p.m. local time

Deadline for Letter of Intent to Bid: (date), 5:00 p.m. local time

RFP Coordinator: (Name, Title & Address)

(RFP Coordinator's)
Tel: (Phone#) e-mail: (e-mail address) Fax: (Fax#)
For the Deaf or Hard of Hearing: 1-800-606-0215

Completed Proposals Due: (date), not later than 2:00 p.m. Local Time

AT

Division of Purchases
Burton M. Cross Building, 4th Floor, 111 Sewall Street
9 State House Station, Augusta ME 04333-0009

Contract Administration and Conditions



- The successful bidder will be required to execute a standard State of Maine Agreement. A list of Applicable Riders is as follows:
 - Rider A: Specification of Work to be Performed
 - Rider B: Method of Payment and Other Provisions
 - Rider C: Exceptions to Rider B
 - Rider D: Additional Requirements
 - Rider E: Program Requirements
 - Rider G: Identification of Country in Which Contracted Work Will Be Performed
 - Rider I: Assurance of Compliance
- Allocation of funds is final upon successful negotiation and execution of the contract, subject to the review and approval of the State Purchases Review Committee
 - Regulations of the Department of Administrative and Financial Services, Bureau of General Services, Division of Purchases: Ch. 110, 3.B.i.:
<http://www.maine.gov/purchases/policies/chapter110.html>

Proposed Operational Model Design

Program Overview



- Program will be statewide with consistent design in urban and rural areas
- All MaineCare populations will be phased in over a three-year period
- State intends to contract with two MCOs on a full-risk basis
- Managed care will serve as a key component for Health Care Reform
- Improved care, service coordination, quality improvement, and encouraging innovation at the provider level are cornerstones of the new program

A Key Component for Health Care Reform



- MCOs will be evaluated on:
 - Their strategies to develop partnerships and new payment relationships with providers that promote accountability, quality improvement, and provider capacity
 - Their strategies to improve care coordination and outcomes for special needs populations
 - Their strategies for improving the delivery of long term care services to encourage less use of nursing home services
 - Their strategies to fully utilize and engage community resources to support member needs
- MaineCare is committed to payment reform and will pursue grant and demonstration program opportunities; MCOs will be required to participate in these initiatives
 - Maine selected for Multi-Payer Advanced Primary Care Practice Demonstration program
 - Maine already operates a Patient-Centered Medical Home pilot to support practice innovation
 - Maine looking at the Health Homes Initiative Program
- MCOs will be expected to also sell individual insurance policies on Maine's Health Insurance Exchange in 2014

Other Provider Considerations



- Stability of MaineCare's provider network
 - MCO networks must be open to providers who meet credentialing standards and, at a minimum, are willing to accept FFS rates
 - » Will consider tiering or other approaches in later years of contract
 - MCOs will be required to pay hospitals according to MaineCare's new DRG and APC systems
 - Unless mutually agreed upon, MCOs may not pay less than FFS rates
 - MCOS will propose and implement provider incentive programs
 - Pharmacy will not be carved out, but MaineCare's Pharmacy & Therapeutics Committee will establish the Preferred Drug List/Formulary for both FFS and MCO plans
- Access to services
 - Provider choice will be required
 - Rural access is a recognized challenge
 - Improving dental service is a key issue for MaineCare

RFP and Contract Considerations



- Bidder must be a licensed Maine HMO or have applied for a Maine HMO license 30 days before submitting RFP response
- Bidders will be required to have a Maine HMO license before contract execution with MaineCare
- Provider network development will be evaluated during the RFP response evaluation process
- Rates will be established by MaineCare
 - Databook will be provided
 - Preliminary rates will be published in RFP and final rates will be developed after legislative session to reflect possible program changes and other trend adjustments
- Contracts will be for three years with a two-year renewal option
- MCO participation in Year 3 (when dual eligibles, other special populations, and long term care services are rolled into the program) is conditional on successful completion of a readiness review for these populations and services at the end of the first contract year
 - Failure to pass the readiness review will result in a re-procurement to find a replacement MCO for all populations

Operational and Financial Considerations



- Operational Considerations
 - MaineCare will use an enrollment broker to assist members with MCO and PCP selection
 - Function may transfer to the Health Insurance Exchange in 2014
 - Maine will develop an algorithm for auto assignment of members; algorithm may be adjusted annually to reflect program needs
 - Members in current Schaller and APS care management programs must be seamlessly transitioned
- Financial Considerations
 - PMPM rates will be risk adjusted
 - Re-insurance options are still being considered
 - Prompt payment and other Service Level Agreements (SLAs) will have penalty provisions

Quality Improvement



- MaineCare will select a set of core quality measures
 - Will be described in the RFP
 - Will be subject to incentives and penalties
- Each year a subset of measures will be selected from core measures for the MaineCare Quality Incentive Program
 - Incentives will be paid if performance improves
 - Penalties will be assessed if performance declines
 - Maine looking to move beyond MCO/HEDIS measures
- NCQA certification will be required in addition to quality requirements for Maine licensed HMOs
 - Bidders will not need to have NCQA at time of RFP submission, but must commit to obtaining it

Participant Question & Answer/Feedback



All questions will be recorded and posted, along with the answers, on the Managed Care Initiative website

10 minute Break

Update from Bureau of Insurance

MCO Limited License Checklist

**FOR DISCUSSION
DRAFT
PURPOSES ONLY**



Maine’s Bureaus of Insurance will provide the opportunity for bidders to apply for a limited license to bid on this RFP. The application will be evaluated jointly between BOI and DHHS.

	Requirement	BOI	DHHS
1	Application (see checklist)		
2	Health and Human Services has issued a certificate of need or has certified that all requirements are met	WAIVE	
3	The HMO is financially responsible and can reasonably be expected to meets its obligations to enrollees and prospective enrollees.		
4	<p>The HMO complies with the minimum surplus requirements of section 4204-A</p> <p>A. Initial Minimum Surplus of \$1.5 Million</p> <p>B. Maintain Minimum Surplus of the greater of:</p> <ol style="list-style-type: none"> One Million dollars % of annual premium revenues as reported in the annual financial statement covering the immediate proceeding fiscal year on the first \$150,000,000 and 1% of annual premium on the premium in excess of \$150,000,000. An amount equal to the sum of 3 months uncovered health care expenditures reported for the previous fiscal year. An amount equal to 8% of annual health care expenditures except those paid on a capitated basis. An amount equal to the company action level risk-based capital. 		
5	The enrollees are afforded an opportunity to participate in matters of policy and operation pursuant to section 4206.		

 Indicates that requirement will be reviewed by designated agency

MCO Limited License Checklist


(Continued)

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	Requirement	BOI	DHHS
6	Nothing in the proposed method of operation, as shown by the information submitted pursuant to section 4203 or by independent investigation, is contrary to the public interest.		
7	Any director, officer, employee or partner of a HMO who receives, collects, disburses or invests funds in connection with the activities of that organization shall be responsible for those funds in a fiduciary relationship to the organization.		
8	The HMO shall maintain in force a fidelity bond or fidelity insurance on those employees and officers of the HMO who have duties as described in number 8, in an amount not less than \$250,000 for each HMO or a maximum of \$5,000,000 in aggregate maintained on behalf of HMOs owned by a common parent corporation, or such sum as may be prescribed by the Superintendent.		
9	The HMO provides a spectrum of providers and services that meet patient demand.		
10	The HMO demonstrates a plan for providing services for rural and underserved populations and for developing relationships with essential community providers within the area of the proposed certificate.		
11	Each HMO shall provide basic health care services.		
12	The HMO organization shall invest funds only in accordance with chapter 13-A with some real estate exceptions.		

 Indicates that requirement will be reviewed by designated agency

MCO Limited License Checklist


(Continued)

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	Requirement	BOI	DHHS
13	A HMO shall deposit with the Superintendent in a Fair Market Value of not less than an amount equal to the greater of \$100,000 or 120% of the HMO's liability for uncovered expenses for enrollees as of the end of the most recent calendar quarter including but not limited to the liability for incurred but not reported claims.		
14	Every contract between a HMO and a participating provider of health care services must be in writing and must set forth that in the event the HMO fails to pay for health care services as set forth in the contract, the subscriber or enrollee may not be liable to the provider for any sums owed by the HMO.		
15	The Superintendent shall require that each HMO have a plan for handling insolvency that allows for continuation of benefits for the duration of the contract period for which premiums have been paid and continuation of benefits to covered persons who are confined on the date of insolvency in an inpatient facility until those covered persons are discharged or upon expiration of benefits.		
16	An agreement to provide health care services between a provider and a HMO must require that, if the provider terminates the agreement, the provider shall give the HMO not less than 60 days' notice in advance of termination. The agreement must not require more than 90 day's notice after an initial participation period not to exceed 6 months.		
17	The HMO conforms to the definition of an HMO under section 4202-A, subsection 10.		

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MCO Limited License Application

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PURPOSES ONLY**



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	Submitted Materials	BOI	DHHS
A	A copy of the basic organizational document, if any, of the applicant such as the articles of incorporation, articles of association, partnership agreement, trust agreement or other applicable documents and all amendments thereto; <ul style="list-style-type: none"> • Article of Incorporation • Organizational chart for Ownership Structure • Organizational Chart for Management Structure 		
B	A copy of the bylaws, rules and regulations, or similar document, if any, regulating the conduct of the internal affairs of the applicant;		
C	A list of the names, addresses and official positions of the persons who are to be responsible for the conduct of the affairs of the applicant, including all members of the board of trustees, executive committee or other governing board or committee, the principal officers in the case of a corporation and the partners or members in the case of a partnership or association;		
D	A copy of any contract made or to be made between any providers or persons listed in paragraph C and the applicant;		
E	A statement generally describing the health maintenance organization, its health care services, facilities and personnel;		
F	A copy of the form of evidence of coverage to be issued to the enrollees;		
G	A copy of the form of the group contract, if any, which is to be issued to employees, unions, trustees or other organizations.		


Indicates that materials will be reviewed by designated agency

MCO Limited License Application


(Continued)

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	Submitted Materials	BOI	DHHS
H	Financial statements showing the applicant's assets, liabilities and sources of financial support. If the applicant's financial affairs are audited by independent CPAs, a copy of the applicant's most recent regular certified financial statement shall be deemed to satisfy this requirement, unless the Superintendent directs that additional or more recent financial information is required for the proper administration of this chapter.		
I	A financial feasibility plan that includes detailed enrollment projections, the methodology for determining premium rates to be charged during the first 12 months of operations certified by an actuary or other qualified person, a projection of balance sheets, cash flow statements showing any capital expenditures, purchase and sale of investments and deposits with the State, income and expense statements anticipated from the start of operations until the organization has had net income for at least one year and a statement of the sources of working capital and any other sources of funding.		
J	A power of attorney duly executed by such applicant, if not domiciled in this State, appointing the Superintendent and his/her successors in office, duly authorized deputies, as the true and lawful attorney of such applicant in and for this State upon whom all lawful process in any legal action or proceeding against the HMO on a cause of action arising in this State may be served;		
K	A statement reasonably describing the geographic area or areas to be served;		
L	A description of the complaint and grievance procedures to be utilized as required under §4303 subsection 4 and §4211.		

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MCO Limited License Application

(Continued)

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	Submitted Materials	BOI	DHHS
M	A description of the proposed quality assurance program, including the formal organization structure, methods for developing criteria, procedures for comprehensive evaluation of the quality of care rendered to enrollees, and processes to initiate corrective action and reevaluation when deficiencies in provider or organizational performance are identified.		
N	A description of the mechanism by which enrollees will be afforded an opportunity to participate in matters of policy and operation under section 4206, subsection 2 by establishing a mechanism to afford the enrollees an opportunity to participate in matters of policy and operation through the establishment of advisory panels, by the use of advisory referenda on major policy decisions or through the use of other mechanisms.		
O	A schedule of rates with supporting actuarial and other data;		
P	A description of a procedure to develop, compile, evaluate and report statistics relating to the costs of its operations, the pattern of utilization of its services, the availability and accessibility of its services and such other matters as may be reasonably required by the Commissioner of Human Services;		
Q	A description of procedures to be implemented to meet the protection against insolvency requirements in section 4204, subsection 2-A, paragraph D (see below) and section 4204-A (Surplus requirements); and Section 4204, subsection 2-A, paragraph D states that the HMO is financially responsible, complies with the minimum surplus requirements and can reasonably be expected to meet its obligations to enrollees.		

Indicates that materials will be reviewed by designated agency

MCO Limited License Application


(Continued)

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	Submitted Materials	BOI	DHHS
R	A list of names and addresses of all physicians and facilities with which the HMO has or will have agreements. If products are offered that pay full benefits only when providers within a subset of the contracted physicians or facilities are utilized, a list of the providers in that limited network must be included, as well as a list of the geographic areas where the products are offered. This paragraph may not be construed to prohibit a HMO from offering a health plan that includes financial provisions designed to encourage members to use designated providers in a network in accordance with §4303, subsection 1, paragraph A.		

 Indicates that materials will be reviewed by designated agency

Proposed Populations & Services Approach

Guiding Principles for Populations and Services



- To address the individual's whole health, including physical, behavioral, and oral health.
- To maintain one system of care for family units.
- To reflect robust member input in the program design.
- To align financial incentives for managing and coordinating services.
- To maintain a long-term partnership among members, providers, contractors and the Department.

Phasing of Populations into Managed Care



The Department is proposing a three-year approach to phase populations into managed care, postponing some of the more specialized populations for Year 3

Mandatory in Year 1	Voluntary in Year 1; Mandatory in Year 2	Excluded in Years 1 and 2; Mandatory in Year 3
<p>All populations are non-duals</p> <ul style="list-style-type: none">• Parents & children, except children with special needs• People on the non-categorical waiver• Adults, older adults, and adults with disabilities living in the community, except certain groups with higher long term service needs. (See Year 3 groups)	<ul style="list-style-type: none">• Children with special needs	<p>People who are dually eligible in Year 1 and 2 groups, plus:</p> <ul style="list-style-type: none">• People in institutions (NF and ICF-MR)• Adults in residential settings• People receiving home and community based waiver services and other long-term supports• People who spend down or are medically needy; have other insurance

Mandatory Enrollment – Year 1



All of the following non-dually eligible MaineCare members:

- Parents and Children, except children with special needs
- People on the non-categorical waiver (Adults without Dependent Children)
- Adults, older adults, and adults with disabilities living in the community, except those in groups excluded until Year 3

Mandatory Enrollment – Year 1



Groups of Special Interest

- **Adults with severe and persistent mental illness – mandatory in Year 1**
 - But not all the services (community residences and community integration)
 - These services are added to capitation in Year 3
- **People with brain injury**
 - Who are **not** in residential facilities – mandatory in Year 1
 - Who are in residential settings – mandatory in Year 3
 - Rehab services for people with brain injury are added to capitation rate in Year 2

Voluntary Enrollment – Year 1



- **Children with Special/Complex Needs**
 - Voluntary enrollment in Year 1
 - Mandatory enrollment in year 2
 - Will need to get a Managed Care Waiver (1915(b))
- **People who change from mandatory to voluntary status**
 - Ex: children who develop a special need
- **People who change from non-dual to dual status**

Definition of Children with Special Needs



- **Children identified using RAC (eligibility) codes**
 - Children who are eligible based on SSI
 - Children who are in state custody, foster care, child protective custody, and adoptive assistance
- **Children with conditions severe enough to be eligible for or use certain services:**
 - Children with serious emotional disturbance
 - Children with intellectual disability/autism spectrum disorder who meet diagnostic and functional eligibility criteria for treatment and special services
 - Children with medical conditions (PDN, Levels IV and V)

Groups Excluded Until Year 3



- **People in institutions**
 - Nursing Facilities and ICF-MRs
- **People in residential settings**
 - Residential care facilities (older adults, adults with MR/DD, people with brain injury)
 - Adult Family Care
 - Assisted Living
- **People receiving long term services and supports in the community**
 - HCBS 1915(c) Waivers (Older adults, adults with physical disabilities, adults with MR/DD)
 - Private Duty Nursing
 - Children eligible for Katie Beckett
- **Other**
 - Medically needy/spend down
 - People with other health insurance
- **Members of federally recognized tribes (Excluded all 3 years)**

Phasing of Services into Managed Care



- **Year 1: Most hospital/medical/allied health services** will be managed services (i.e. included in the capitation rate) of the managed care entity in Year 1
- **Year 2: Some special services** will be fee-for service (carved out of the capitation rate) in Year 1 and managed services in Year 2
- **Year 3: Most home and community based and long term care services** will be fee for service (carved out of capitation rate) in Years 1 and 2; and managed services in year 3

Year 1: Services included in Capitation Rate as Managed Services



- **Hospital**
 - Acute (inpatient and outpatient)
 - Psychiatric
- **Physician Services**
- **Ambulatory Services**
 - Ambulatory Care Clinics
 - Ambulatory Surgical Centers
 - Federally Qualified Health Centers
 - Rural Health Clinics
 - V.D. Screening Clinic Services
- **Lab Services/Medical Imaging**
- **Occupational/Physical Therapy**
- **Speech/Vision/Hearing**
- **Dental**
- **Pharmacy Services**
- **Other medical/health services**
 - Advance Practice Nursing
 - Ambulance Services
 - Free-standing Dialysis Services
 - Medical Supplies and Durable Medical Equipment
 - Family Planning Services
 - Home Health
 - Podiatry Services
- **Other Special Services**
 - Targeted Case Management
 - Outpatient Mental Health Services
 - Substance Abuse Services
 - EPSDT Services
 - Substance Abuse Treatment Facility Services
 - Developmental and Behavioral Clinic Services
 - Short stay nursing facility services

****Non-Emergency Transportation services are excluded from the capitation rate for all three years.**

Year 2: Services Included in Capitation Rate



Year 1 Services, plus:

- **Special children and rehab services**
 - The following services will be fee for service (carved out of capitation rate) in Year 1 and managed services (included in the capitation rate) in Year 2
 - Rehab and Community Supports for Children
 - Children's Assertive Treatment Services
 - Children's Home and Community Based Treatment
 - Residential Therapeutic Foster Care
 - Multi-dimensional treatment foster care
 - Rehabilitation Services (for people with brain injury)

Year 3: Services added to Capitation Rate



Home and Community Based & Long Term Care Services

Special children and rehab services

- The following services will be fee for service (carved out of the capitation rate) in Years 1 & 2 and managed services (included in the capitation rate) in Year 3

– Institutional Services

- Nursing Facility Services -- long stays
- ICF-MR

– Residential Services

- Residential Care for older adults
- Community Residences for People with Mental Illness
- Community Residences for People with MR; other/brain injury
- Adult Family Care Services and Assisted Living Services

– Other home and community based waiver/long term services and supports

- Community Support Services
- Home and Community Based Waiver Services for older adults, adults with physical disabilities and people on the MR waiver
- Day Health
- MaineCare Hospice Services
- Private Duty Nursing Services
- Consumer directed attendant services

Participant Question & Answer/Feedback



All questions will be recorded and posted, along with the answers, on the Managed Care Initiative website

Next Steps

Next Steps



- Attendees submit questions from today's meeting – Dec. 17, 2010
- Post questions and responses from today's meeting – Dec. 22, 2010
- Issue RFP – May 2011
- Hold bidder's conference – May 2011

Resources and Contact Information



Additional resources on this initiative can be found at:

http://maine.gov/dhhs/oms/mgd_care/mgd_care_index.html

For more information and submit questions, please contact:

sarah.stewart@maine.gov